the bill to shove it through the Congress. The bill in dream form was passed out of the Ways and Means Committee even before it had been drafted or numbered. The vote was strictly on party lines. Moved into the Rules Committee, by which time it had been given a number, HR 7225 was again passed out favorably, again on a party line vote. Meanwhile, *no public hearings were held.* No expert advice was asked. No proponents or opponents outside the two communities had a chance to be heard. No actuarial advice was sought; no financial advice.

These two committees handed the House of Representatives a new measure which will cost an estimated two billion dollars annually. Of course, the money comes from the taxpayers in the form of higher social security taxes for both employer and employee. When and if further medical therapy is added, these taxes will again go up.

On the floor of the House of Representatives, HR 7225, under a suspension of the rules, was limited to 40 minutes' debate. This is popularly known as the "gag rule." On a two billion dollar measure, affecting millions of people, after only 40 minutes of debate, the bill was passed by a vote of 372 to 31. The strategy here was to put every Congressman in the spot where, with elections coming up in 1956, he would be too embarrassed to vote against a new extension of the give-away program. It even appears that this same strategy may have pervaded the White House, where it might give pause to a veto when and if the bill goes through the Senate.

At this writing there seems some hope that the Senate will not act favorably on HR 7225 during this session of Congress. But just wait for the next session. Back will come HR 7225, with a few new clauses and a new number. Will the Senate still have the courage to step in and stop this further incursion into our personal lives and fortunes? Or will the proponents of this legislation have gathered enough added strength to push their bill through both houses of Congress?

The medical profession will do well to keep a watchful eye on this back-door approach to socialized medicine. It is obvious that the planners for tomorrow are still at work and as full of cunning as ever.

LETTERS to the Editor . . .

Chronic Prostatitis

THIS IS A LETTER to the Editor if such a forum exists. The article published in June, 1955, of CALIFORNIA MEDICINE entitled "Chronic Prostatitis: A Psychosexual Approach," by David Rosenbloom, M.D., is in my opinion so misleading that I cannot refrain from taking issue with the ideas that are expressed. At the outset I will admit that part of the problem is one of semantics since the misconceptions which are fostered in this article are often the result of terminology and furthermore I agree with many of the observations which the author made regarding symptomatology and objective findings in the group of patients he was talking about. The real trouble lies in the label which he applied to this group of cases.

In the first place Dr. Rosenbloom was not really talking about chronic prostatitis at all, as the term is generally understood by urologists. If he had used the word which he coined, "prostatosis," instead of the term *prostatitis*, he might not be challenged. The group of symptoms which he described as "a discharge of thin, mucoid material from the urethral meatus, worse upon arising . . ." which "often stains the underclothing . . . seems to come and go without definite causal relationship to daily events" . . . often is "associated with mild dysuria, terminal dysuria, a feeling of incomplete urinary emptying" and discomfort in the perineum, low lumbar area, sacral area and sometimes in the testes and urethra—that group is certainly a commonly observed syndrome even in northern California, but to label this *chronic prostatitis* is completely improper and is misleading to those in general practice or other specialties who do not see it often enough to differentiate it from true prostatitis by the very simple methods which are at hand. I am sure that most urologists also agree that this is a psychosexual disturbance. No issue is taken with the author on the method of handling this type of case. Let's talk about prostatitis, however, because that is what the author labeled his article, and that is what most readers might think he is talking about.

Chronic prostatitis is a real, clear-cut, clinical entity, simple to diagnose when the proper methods are applied but obscure as to etiology and the treatment of which is frequently unsatisfactory and prolonged. That the treatment is not entirely satisfactory in many cases and has made little or no progress in an era when great progress has been made in other medical conditions, is no reason to place the diagnosis in obscurity, in my opinion.

The condition is observed sometimes in the late teens but more commonly in the 20's, 30's and 40's and somewhat less commonly in the older age groups. Various complaints may bring the patient to the doctor. The patient commonly complains of fatigue without much else to go with it. This he frequently terms "lack of pep," loss of his usual ambition both at work and play, sometimes a moderate loss of libido, frequently a mild low backache in the sacral area which is worse in the morning upon arising and improves after some physical activity and moving about in the morning. This type of individual will have completely negative physical findings and the urine is also usually completely negative. Unless the doctor is thinking of prostatitis as a possibility he will miss the opportunity to make the diagnosis at this stage. The prostate is ordinarily not remarkable to palpation and it is only upon purposeful milking of the prostatic secretion and examination under the microscope that the diagnosis of prostatitis can be made. About half of the group will have some associated urinary symptoms which are in the nature of frequency, urgency and dysuria.

Patients with such symptoms usually are seen by urologists and the two-glass urine test will show a significant number of pus cells in the first glass with definitely less or none at all in the second glass of urine. Here the clue is obvious and a prostatic massage with the obtaining of the prostatic secretion for examination is all that is needed to make the diagnosis.

In my experience fewer than 25 per cent will have noticed any urethral discharge in association with the above symptoms. Cases in which there is urethral discharge are not necessarily cases of chronic prostatitis; they may be owing to psychosexual disturbance. The distinction is easily made by the above mentioned methods. A signicant number of patients with chronic prostatitis whose symptomatology is outlined here, will not show more than an occasional pus cell in the prostatic secretion in the first specimen obtained by massage. Sometimes even the second specimen three or four days later will have few pus cells, but the third massage will usually produce the typical flood of many pus cells in the prostatic secretion. The lesson here is that if the story is very typical, one should persist in several diagnostic massages until prostatitis has been definitely ruled out.

Acute prostatitis is not, as is implied by the author of the article, an entirely different condition; and, contrary to his statement, I believe that acute prostatitis will usually not respond to the antibiotics. My own experience, over a period of about the same length of time that the author mentions, is that in fewer than 20 per cent of cases will there be any real change in the prostatic secretion with any type of antibiotic. Antibiotics should be used, however, because in these cases the bladder, especially the trigone and sometimes the kidney pelves, are involved in the infection and there is associated fever, leukocytosis, increased sedimentation rate and sometimes epididymitis. All of these complications (because that is what they are) of prostatitis will respond to the sulfonamides or the antibiotics quite promptly. What remains after the acute phase is over is chronic prostatitis and that the prostate gland is quite vascular is true from the surgical standpoint, but his intimation that the antibiotics administered by mouth or parenterally infuse the gland in adequate concentration is an unjustified deduction which does not follow the observations of other investigators. In fact, the contrary can be more logically assumed.

The most important point, I think, that should be made about prostatitis, either acute or chronic, is that it is the cause of the overwhelming majority of symptoms in the urinary tract of the male. General practitioners could deal with this large percentage of the urological problems presenting themselves if they would use a step-by-step procedure which includes physical examination of the genitalia, a two-glass urine test and a thorough prostate examination both by palpation and a stripping of the gland to obtain the prostatic secretion for microscopic examination.

Finally, it is perfectly patent that the treatment of prostatitis leaves much to be desired. Prostate massage, done properly, remains the basic treatment. Other procedures such as urethral calibration with sounds to rule out strictures and the treatment of complications with sulfonamides and antibiotics are necessary, but most of the other things such as irrigations and instillations have fallen by the wayside. A significant number of patients who do not respond to the standard methods can be cured by the direct injection of the prostate through the perineum with a spinal-type needle, using such antibiotics as penicillin, neomycin or terramycin.

Despite all the shortcomings of the treatment of prostatitis, I feel that it is quite important not to confuse the profession with articles such as this for the reasons that I have tried to outline above.

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Editor, CALIFORNIA MEDICINE:

THANK YOU for your kindness in permitting me to answer Dr. Burns' letter. Careful reading of my paper would demonstrate immediately that the term "prostatosis" was suggested as a substitute for "prostatitis" precisely because of the greater ac-